Department of HUMAN SERVICES

KELLY GARCIA, DIRECTOR

HEALTHY COMMUNITIES WORKGROUP MEETING MINUTES
DECEMBER 12TH, 2019 – 9:00 A.M. – 11:00 A.M.

HEALTHY COMMUNITIES WORKGROUP MEMBERS

Jeffrey Jones	Amerigroup	**Gerd Clabaugh**	*Iowa Department of Public Health*
John Hedgecoth	*Amerigroup*	**Sarah Reisetter**	*Iowa Department of Public Health*
Kathy Gifford	*Health Management Associates*	**Linda Miller**	*Iowa Department on Aging*
Jami Haberl	*Healthiest State Initiative*	**Chuck Palmer**	*Iowa Healthcare Collaborative*
Cindy Fiester	*Healthy Linn Care Network*	**Jennifer Nutt**	*Iowa Hospital Association*
Liz Matney	*IGOV*	**Dr. Michael Romano**	*Iowa Medical Society*
Beth Riha	*IHC*	**Sarah Dixon**	*Iowa Primary Care*
Mike Randol	*IME*	**Aaron Todd**	*Iowa Primary Care Association*
Kelly Garcia	*Iowa Department of Human Services*	**Mitch Wasden CEO**	*Iowa Total Care*
Mikki Stier	*Iowa Department of Human Services*	**Emily Fletcher**	*MercyOne Medical*
Nalo Johnson	*Iowa Department of Public Health*	**Erica Shannon**	*Primary Care Association*
Beth McGinnis	*The Iowa Clinic*	**Dr. Tom Scholz**	*University of Iowa Hospitals and Clinics*
Dr. Christi Taylor	*The Iowa Clinic*	**Beth Hodges**	*Wellmark*
Pam Halvorson	*Unity Point*	**Mary Lawyer**	*Wellmark*
Tessa Heeren	*University of Iowa / Health Policy Research*		

WELCOME AND OPENING REMARKS

Pam Halvorson (Unity Point) Executive Sponsor of Healthy Communities Workgroup opened the meeting by welcoming everyone and recapping the main points and background of the Healthy Communities Workgroup Meeting on October 23rd 2019.

At that meeting several participants were asked to talk collectively about what they are doing in the overarching population health realm. This was to get a sense of whether multiple groups were doing much of the same things individually; instead of using that collective IQ and energy to bring together and focus in on what works within different communities.

Linda Miller, The Director of the Iowa Department of Aging was introduced and went into the first topic of this meeting; the discussion of the Department of Aging Community Pilots.

AGENDA TOPIC: DEPARTMENT OF AGING COMMUNITY PILOTS

The Department of Aging started out looking at a pilot in Minnesota which was called "*Minnesota Returned to Community*" and we called our pilot "*Iowa Return to Community*".

Minnesota spent 12 years in a transition program that came out of that Department of Public Health and moved to the Department of Aging. *Minnesota Return to Community* has been helping people find the services so they can stay at home and in their communities instead of living in a nursing home long term. In many cases, it's just as safe, and more cost-efficient, for older Minnesotans to live at home. It began as a plan to work in partnership with public agencies and nursing facilities to help nursing home residents return home. Now, it has expanded to enlist the help of all health and home care providers. It starts with a referral to the "*Senior LinkAge Line*" where an expert works one-on-one with the person to help plan to return to independent living. A unique feature of this initiative is that the Community Living Specialist from the *Senior LinkAge Line* stays in touch with the individual over the long-term. The specialist may call or visit for up to five years after the initial consultation.

In In two statewide (Iowa) studies, we found that 92% of people wanted to stay home with support rather than being in a nursing home.

Iowa has five pilot counties: Pottawattamie, Mills, Woodbury, Cass, Clay. They have been going from 6 months up to 18 months. We are keeping demographic data on all the parameters that Minnesota collected. For Iowa, home modifications and transportation to doctor appointments where the two things people needed most. The Department of Aging started meeting with all of the home modification advocates in Iowa. There are approximately 30 in home modification companies that are part of the Livable Homes Coalition.

The department has also hired a staff person, who starts at the end of December, who will be coordinating home modifications. There is also a staff position monitoring the patient transition up to 90 days. If the transition takes longer than 90 days, they are assigned a case worker.

Director Miller wrapped up this discussion reiterating that this is a pilot for a reason. The Department of Aging is trying hard to have the flexibility to change things as they learn more from these pilots. Then they can decide if they are going to apply for an 1115 waiver from CMS because they will have solid data and a base that can prove results.

AGENDA TOPIC: POPULATION HEALTH CARE INITIATIVE UPDATES

MERCY ONE

MercyOne has case managers located in all of their primary care clinics throughout the state. They also have community health workers and social service technicians in north Iowa and central Iowa.

MercyOne uses a survey called: The "*Health Leads Survey*", which covers eight domains and is slightly modified for each subpopulation. This survey and asks the population if they want assistance or if any of their needs are urgent. MercyOne has used this survey for two years.

Approximately 2 in 10 patients have at least one unaddressed social need with the highest need being social isolation. This is followed by food, transportation and health literacy, utilities and housing. When patients identify needs, they partner with a Community Health Worker on resource connections. 65% of patients that we connect resources to confirm that they have used or continue to use the resource that they were connected with.

UNITY POINT

See Attached Slide Show

WELLMARK

Wellmark is working with communities to help make changes to the environment, applied behavioral economics principles and past policies that will create environments that help the broad population make good health choices. The changes to our environment in the last 30 years had caused obesity to double. Eleven percent of kid's calorie intake is coming from sugar sweetened beverages and a lot of natural physical activity has been removed from everyday life.

There also is focus on is social connectedness and nicotine cessation. They are saying: eat well, move more, feel better. It is nutrition, physical activity, social connectedness, nicotine cessation. Wellmark has created a database of over a hundred evidence based items that will help in these areas. Wellmark has a process to help communities create a master plan of what they want to achieve and then identify the tactics can be used to achieve those individual community goals. Master planning would mean helping the communities set up a mission and an overall plan to improve the health of their community.

AMERIGROUP

See Attached Slide Show

IOWA TOTAL CARE

See Attached Slide Show

IOWA PRIMARY CARE ASSOCIATION

Iowa Primary Care Association's model of care is a clinically integrated network that's owned by eleven of the health centers in Iowa. This model focuses on integration of care from a behavioral health, oral health and enabling services perspective for the patient. The model has health information and analytics as a foundational piece and then continues into patient engagement strategies.

About 30,000 thousand patients have been assessed across the state today:

- 14% percent of them have an 8th grade educational level or below
- 44% percent of them are unemployed
- 46% of them have a monthly income of less than five hundred dollars
- 9% are homeless
- 7% are worried about housing
- 19% are moderately or highly stressed
- 19% only talk to people 2 or less times a week

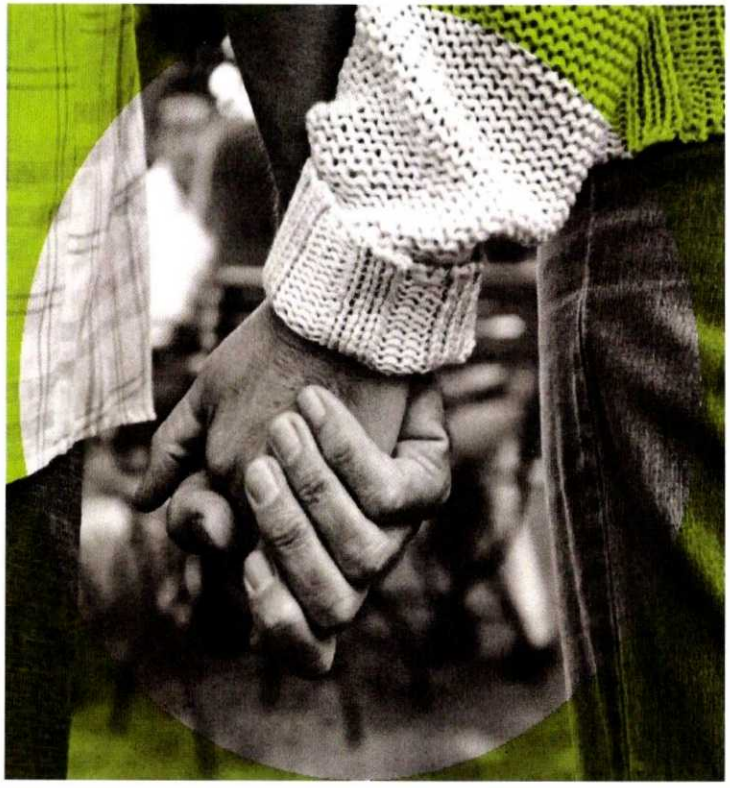
Risk stratification is becoming a focus and working on a model that includes: clinical behavioral utilization and pharmacy and social determinants of health. If there was development of software tools that would help aggregate resources on behalf of all the organizations in the state is another idea. Working on population health would be good to assist with aggregation of information throughout the state.

CLOSING AND NEXT STEPS

In closing, the group discussed recommendations for topics of the next Healthy Communities Workgroup meeting that reflected this meeting discussion. Those suggestions were:

- Dual eligible population (Medicare/Medicaid)
- Role of Economic Development and Population Health
- Applications of Predictive Modelling
- Streamlining and Coordinating Services
- Integration, Synergy and Streamlining
- Review Data of Successful Initiatives
- Work Force Development
- Focus on Systematically Collecting this Social Determinants of Health Data
- Universal Screenings

**We will schedule a follow up meeting late January following the Roundtable meeting.*



iowa total care™

ia health link

Hawki

Iowa Total Care Population Health Resources

Transforming the Health of Our Community One Person at a Time

12/26/2019

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Our Population Health Resources

ITC Population Health Resources

Population Health Resources	Key Initiatives
Member Connections Team	* Can assist with finding members ITC is unable to reach and help with completing the: o Health Risk Screener (HRS); Notice of Pregnancy (NOP); Transfer of Care (TOC) o Identifying Care Gaps including; Doctor Appointments; Dentist; Eye Care o Flu Shot and; Many other health related appointments o Identifying other gaps such as; Transportation; Housing; Safe, reliable phone
Member Engagement Outreach	o Help impact member health by proactively addressing known historic gaps in care. o Focus on member population without Care Managers. o Develop & implement Member outreach programs. o Provide Early Periodic Screening Diagnostic Treatment (EPSDT) performance outreach.
Provider Engagement: Clinical Quality Consultants	o Provider education ongoing as needs are identified; Seasonal campaigns o Promote provider and community partnership; **Health Fairs; Community Events;** o Educational Health Materials; Value Added Resources Transportation, cell phones, etc
Cultural Competency Specialist	o To do this we focus on; Language Services; Oral Interpretation Services for members o Face-to-Face Interpreters for member and provider visits; Health Literacy; o Cultural Competency on Health Disparities for member and provider engagement activities

ITC Population Health Resources

Population Health Resources	Key Initiatives
Transitions Coordinators	Assists members with; o Members served a discharge notice. o Members at risk of incarceration. o Inpatient hospital members with no accepting providers. o Coordinating to organize member transitions. o Assist families when the members needs surpass the family's capacity to care for them.
Resource Specialist	Can assist in finding resources for; o General Resources (Food, Transportation, etc.); Home & Vehicle Modifications o Locating Home Health Aid Services; Moving / Bed Bugs; Utilities/Financial Assistanceo o Waiver Wait List Assistance; Provided legal resource information o Participate in Polk County Residential Options & Roommates Connections o Provide Materials to improve Health Literacy
Employment Support and Services	Services Include: Prevocational Services; Career Exploration; Long Term Job Coaching, Individual Supported Employment; Small Group Supported Employment Access to employment services through Iowa Vocational Rehabilitation Services
Housing Specialist	Can assist the member with: o Resources for housing & shelters; Resources for financial assistance programs. o Communicating with third-party agencies & programs. Assist with urgent housing referral requests. o Collaborate with provider agencies to identify members qualified to receive housing. o Application process & submission; Developing objectives & action steps for obtaining permanent housing. o Help apply for Section 8 waiting list & other related programs when they become available. o Assist in locating funding sources for urgent housing referral requests.

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Rewards members when they complete healthy activities like a yearly wellness exam, annual screenings, tests and other ways to protect their health

Initiative
$30 - HRS in 90 Days
$50 - Notification of Pregnancy (1st Trimester)
$25 - Notification of Pregnancy (2nd Trimester)
$20 - Postpartum Doctor Visit
$20 - Breast Cancer Screening
$45 - Diabetic Care
$20 - Well Child Visit
$20 - Adult Well Visit
$20 - Infant Well Visits
$10 - Annual Flu Vaccine
$20 - Controlling Blood Pressure
Total

https://www.iowatotalcare.com/members/medicaid/benefits-services/healthy-rewards-program.html

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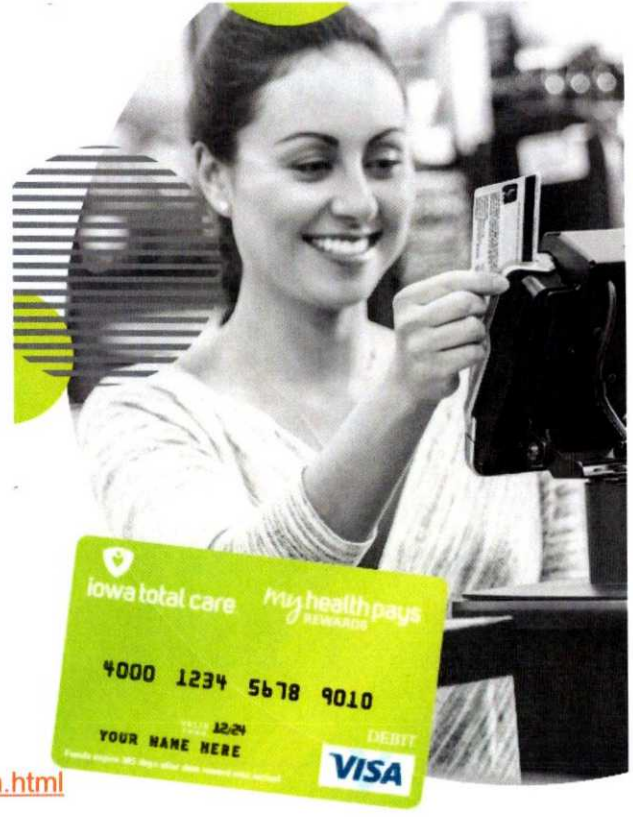
- Members can use rewards to help pay for
  - Utilities
  - Transportation
  - Telecommunications
  - Childcare services
  - Education
  - Rent
  - Walmart **



https://www.iowatotalcare.com/members/medicaid/benefits-services/healthy-rewards-program.html

** May not be used to buy alcohol, tobacco, or firearms products

Integrated Care Management

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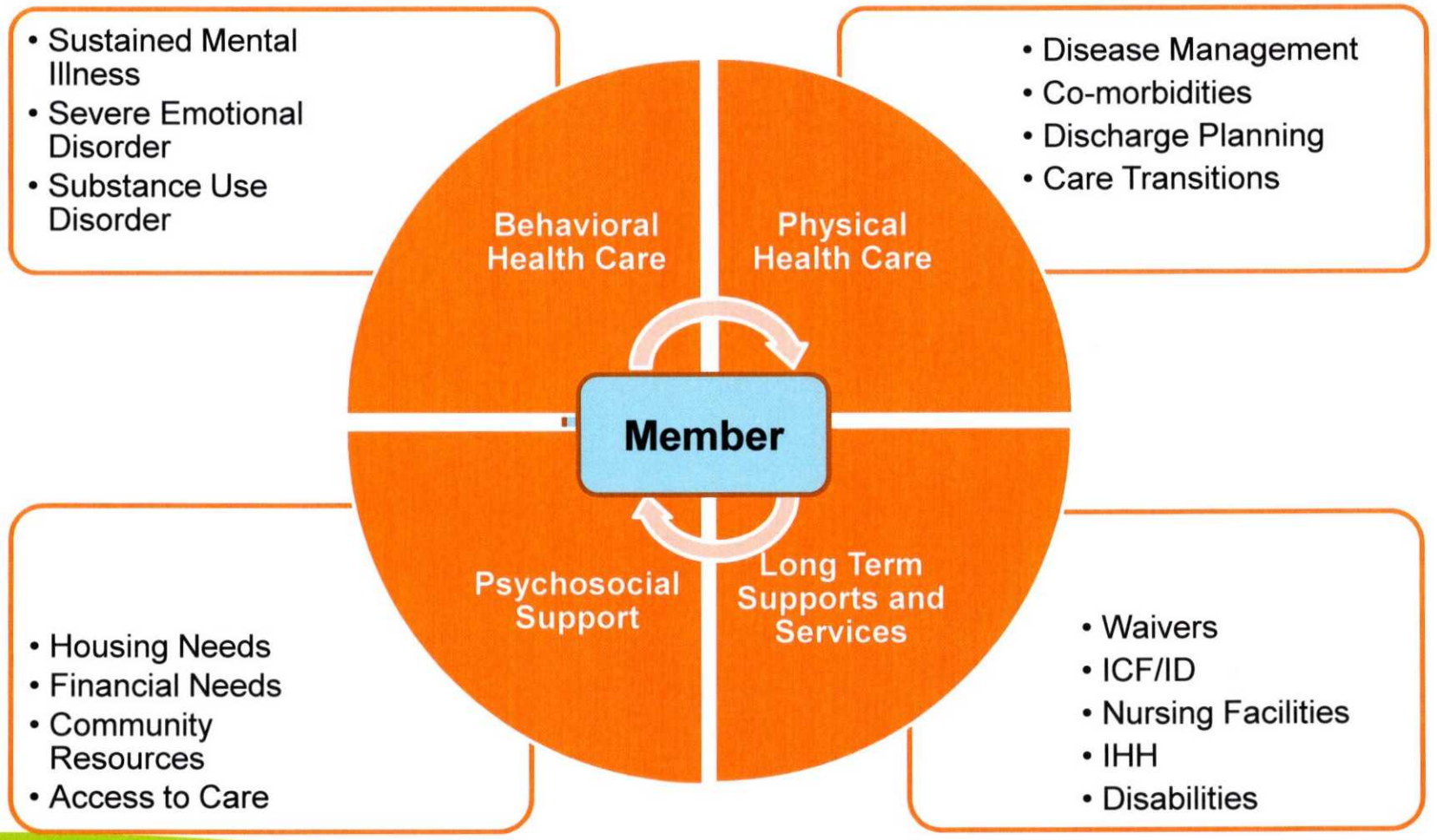
Integrated Care Management (ICM) is the systematic coordination of behavioral and physical healthcare needs.

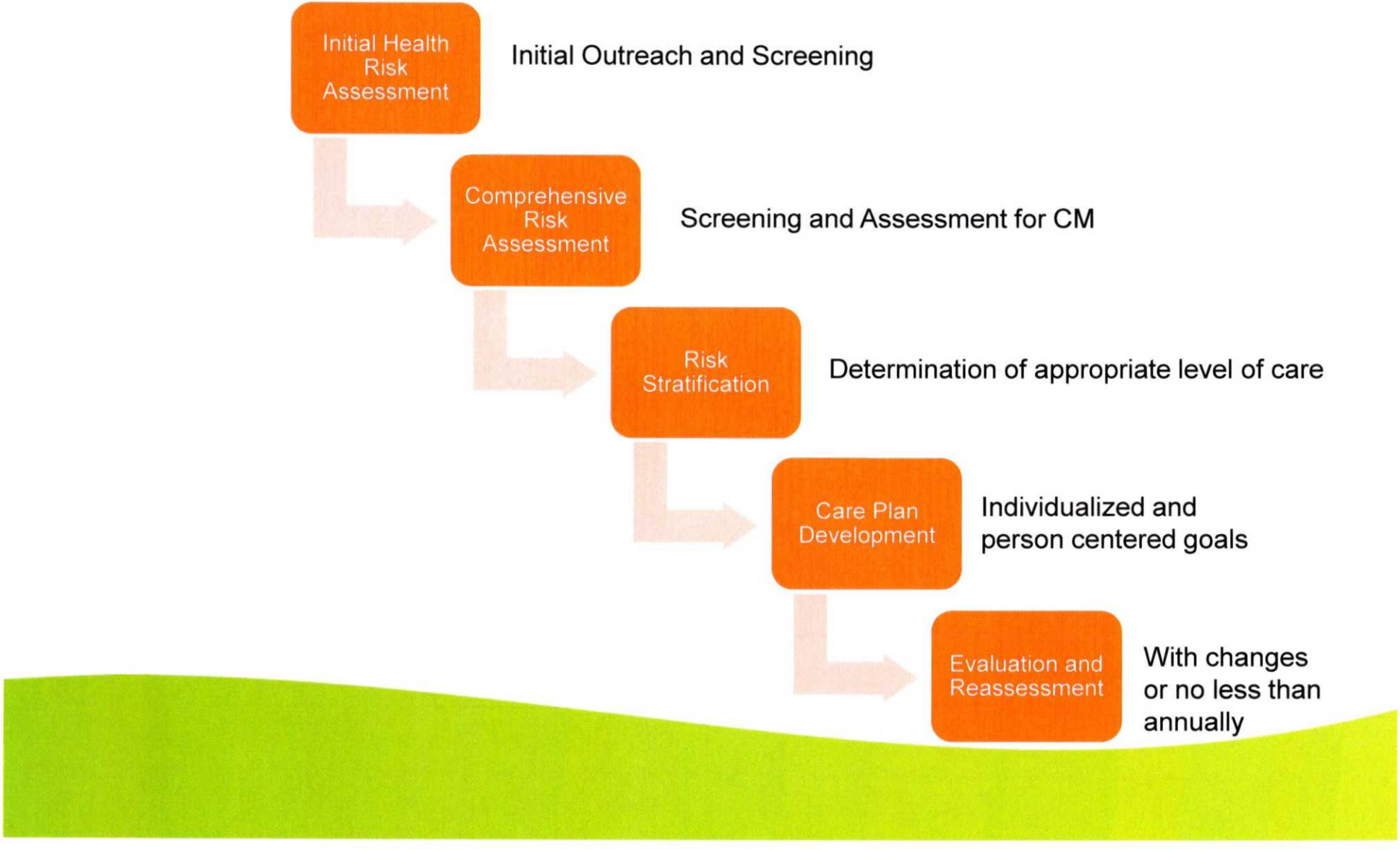
Goals of ICM

- Assist members in achieving optimal health
- Engage in a collaborative care approach
- Appropriate care in the most appropriate setting
- Maximize benefits and resources

ICM and Members



Care Management Process



Continuity & Coordination of Care
Non-LTSS Member

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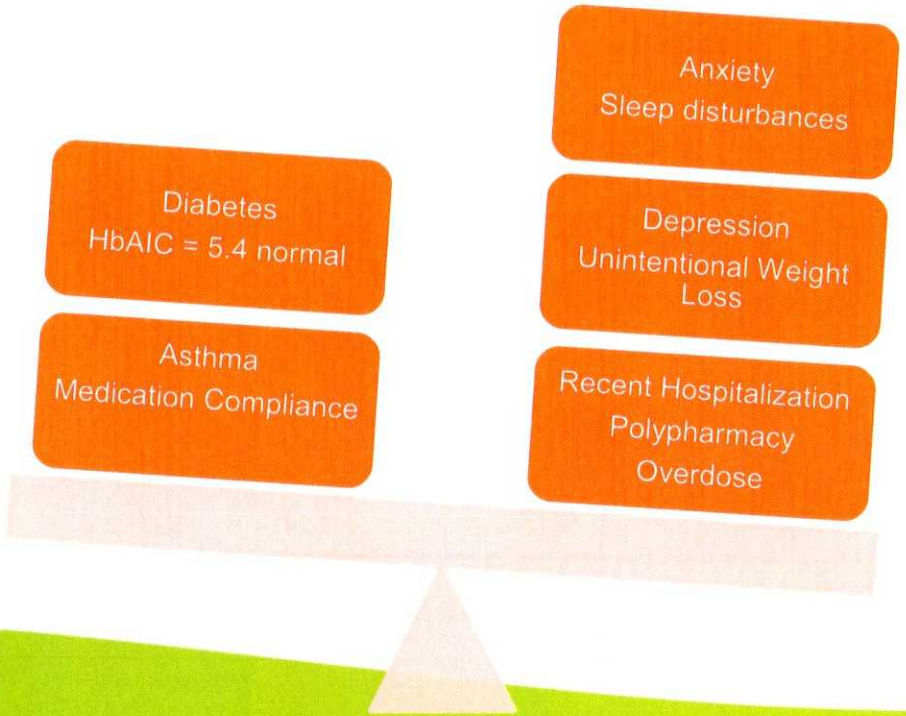
Consulting
Physical Health
Care Manager

Primary
Behavioral Health
Care Manager



Continuity & Coordination of Care
LTSS Member

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Primary
LTSS
Care Manager

Consulting
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Care Manager

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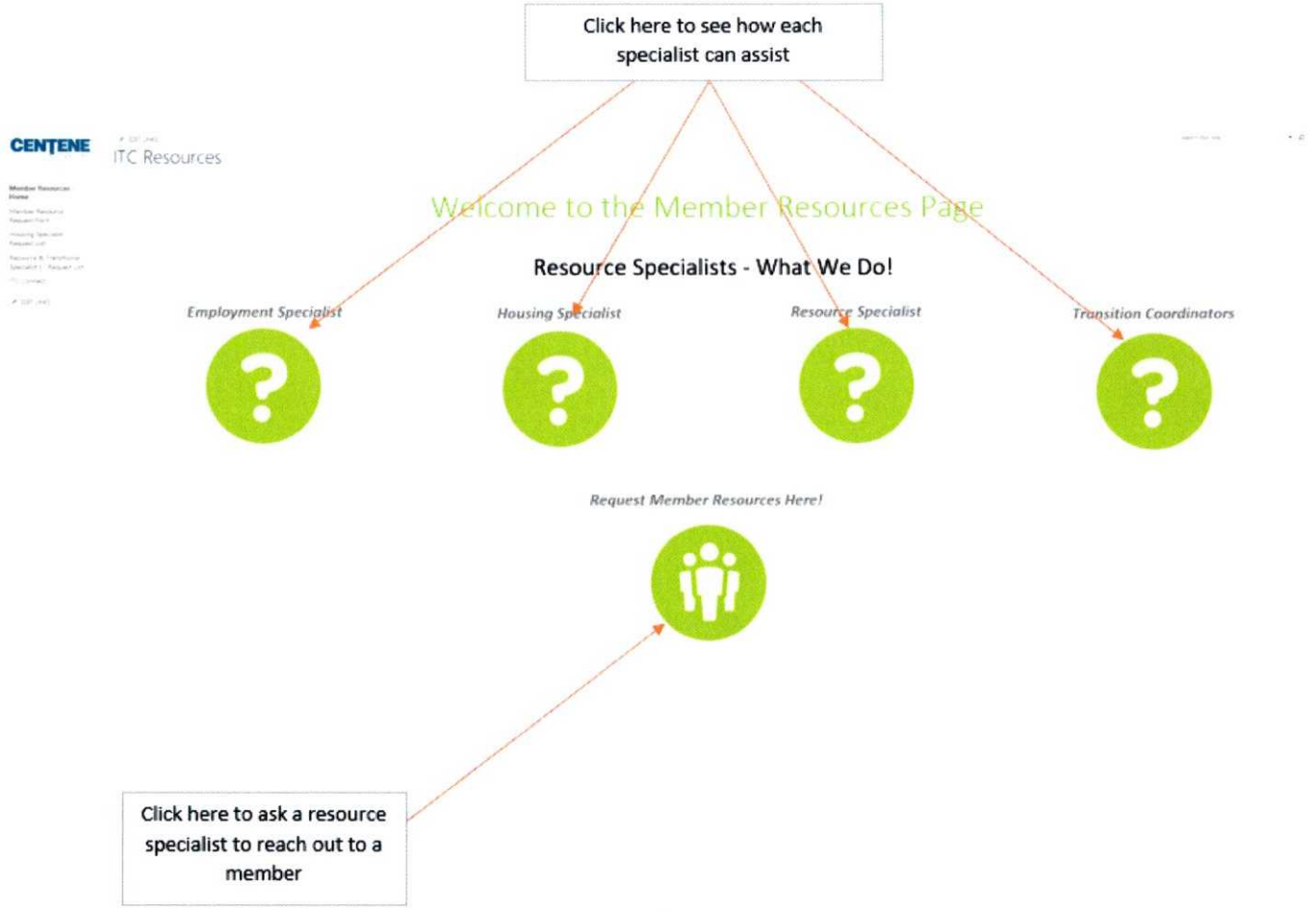
How We Integrate Our Resources…

Member Resources Intranet Site (Internal facing)



Resource Request Form

(**external facing form under development)

Local Community Partnerships

- Healthy LifeStars – partnership to address obesity disparities in the younger population

- Partnership with IDPH
  - Maternal Health Task Force
  - Cancer Prevention Campaigns (w/Amerigroup) – (HPV, Cervical Cancer Screening, Breast Cancer Screening)

- Iowa Health+ Collaborative

UnityPoint Population Health

Program Overview

UnityPoint Health and UnityPoint Accountable Care

UnityPoint Health

UnityPoint Population Health

UnityPoint Health

Key Elements of Population Health:

- Patient Centered Medical Homes
- Combine physician practices with home-based services – Ambulatory Division
- Common tools for cross-continuum use – Common Care Plan, Transitions of Care tools, Heat Map, Predictive analytics, Dashboards, Opportunity Summarys
- Clearly defined roles for Team members within the Ambulatory and Hospital settings
  - Integrated Care Management
  - Access to Pharmacists, Social Worker, MTM,
- Patient Identification
  - Medical Risk profiles – Including changes in vulnerability on transitions
  - Social Determinants
  - Clinician Identification
- Prioritize patients in risk contracts. Initial focus Medicare – Claim data used to determine effectiveness of innovations
- Community Partnerships – Including C3s

UnityPoint Population Health

UnityPoint Health

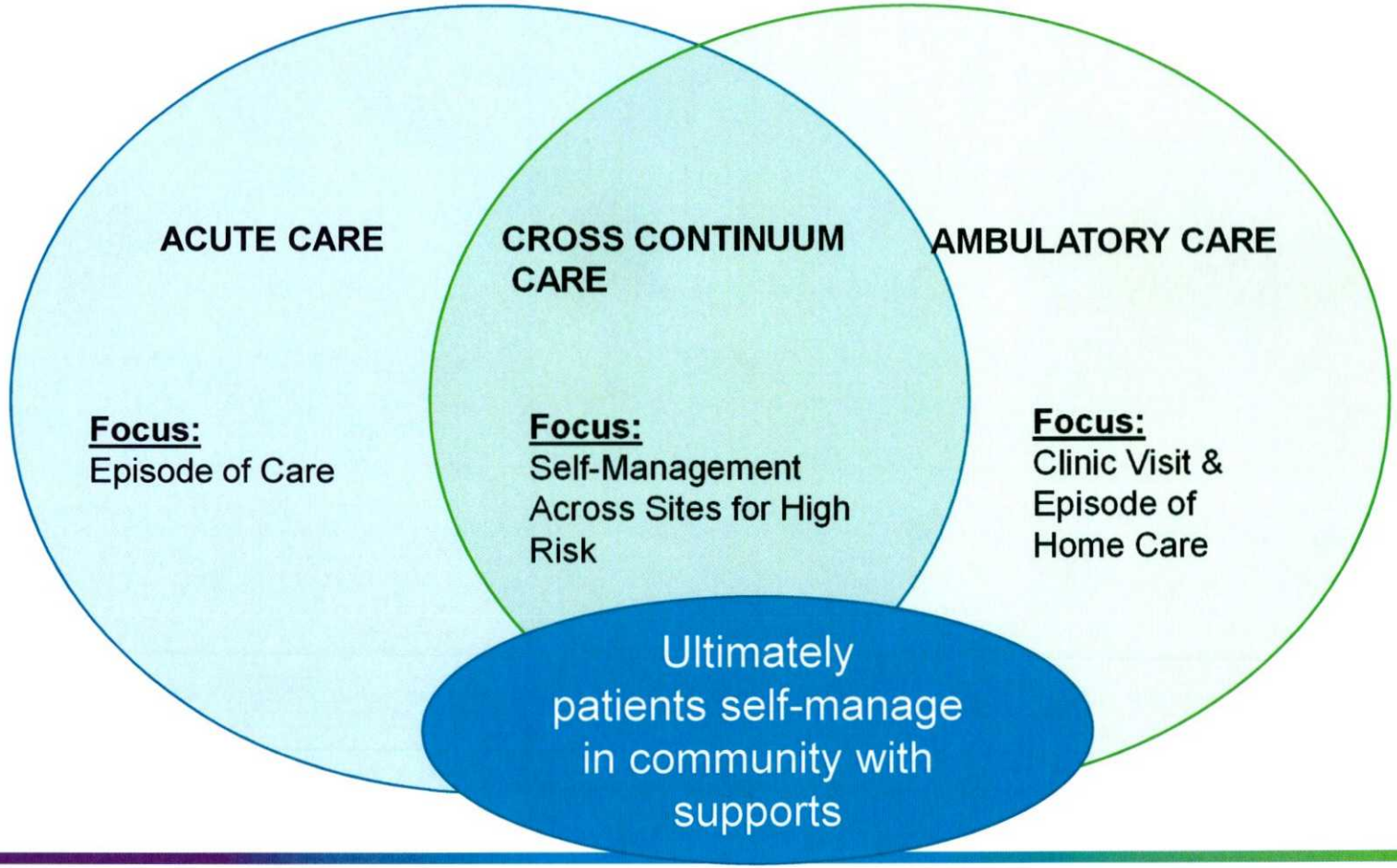
Key Elements of Population Health:

- Care at Home -
- Hospital at Home
- Behavioral Health Integration – UnityPoint Priorities
  - Integrated Health Homes
  - Community Mental Health Centers
  - Co-located therapists
  - Telehealth Integration
- Benefit Enhancements in Medicare programs – Pioneer and Next Generation
  - Three-day waiver
  - Post Discharge Home Visits
  - Care Management Home Visits
  - Part B Cost sharing
  - Gift card
  - Asynchronous telemedicine

UnityPoint Population Health

UnityPoint Health

Resources, Roles & Responsibilities – Acute/Ambulatory Care and Cross Continuum Blend



Integrated Care Management

UnityPoint Health

Care Management Population

- Adult High-Risk as identified by predictive analytics and provider judgement (75/25). Tend to be chronically ill with multiple conditions.
- Focus on population with probability >30% admission risk
- Goal is to decrease illness burden and avoidable utilization
- Interdisciplinary team focus with Social Work and MTM Pharmacist support

Care Model Outcome Metrics:
Central Iowa, Cedar Rapids, Quad Cities, Waterloo Regions

Report summary: The current data show a utilization reduction of 119 inpatient admissions, which indicates that we would have expected these 2,116 Care Management patients to have had 119 more admissions per month, based on their historical patterns, than we have actually observed. These reduced rates of admission each month lead us to believe that the Care Management program is making an impact in reducing costly and inconvenient hospital stays. The other metrics similarly show positive improvement for this group of patients.

Data Pulled Date: 11/15/2019

	Number of Patients[+]	Monthly Rate Before CM*	Monthly Rate During CM	Change in Utilization Per Month
IP Admission Rate	2,116	0.1278	0.0716	-119
Readmission Rate	2,116	0.0393	0.0278	-24
ED Utilization	2,116	0.1188	0.0905	-60

Notes:

[+] Patients are continuously enrolled. These counts represent active patients in Care Management as of 11/15/2019 and patients who have exited the program after at least 6 months of enrollment.

* Monthly rates before CM were developed using previous 6 months of patient experience before Care Management enrollment.

Calculations:

Sample calculation for IP Utilization Prior Rate: 4 Admissions over 6 months across 4 patients prior to CM enrollment = 4 ÷ 6 ÷ 4 = 0.1667

Sample calculation for IP Utilization Post Rate: 1 Admission over 2 months across 4 patients post CM enrollment = 1 ÷ 2 ÷ 4 = 0.1250

UnityPoint Health

Thank You

Questions?

Pamela M. Halvorson

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Population Health Initiatives Overview

Amerigroup Iowa
December 12, 2019
Iowa Healthy Communities Workgroup

Amerigroup
An Anthem Company

Amerigroup Iowa Clinical Population Health "Wins"

Initiatives that have positively influenced trends among our Iowa Medicaid members to date

Member Transitions

- **Increased access to full array of Medicaid Services** – allowing eligible members from the more limited health and wellness plan to convert to the full array of Medicaid services where medically necessary. The expanded array includes transportation, community mental health and an expanded vision and outpatient substance abuse services.
- **Increased Speed of Return to Home** -- Skilled nursing facility (SNF) length of stay has decreased overall, due to active individual member outreach, discharge planning and case management to get members home as they recover from acute illness or injury.
- **Increased Independent Living Opportunities** -- We have incentivized providers and members to collaborate to return custodial nursing facility residents to independent living where appropriate and member chooses.
- **Increased Community Tenure Without Hospital Readmission** – Rate of members returning to the hospital is down due to our dedicated discharge planning team helping members access the full array of supports and services to keep them in the community.

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Maternal-Child Health

- Mothers and Children are a core focus of Iowa's Medicaid program
- Case management -- Amerigroup Iowa provides individualized case management services for members who are high risk during pregnancy and postpartum.
  - *Our case managers connect members with resources they may need, for example car seats, baby supplies, county pregnancy programs, even housing.*
  - *We work with our members to ensure they attend postpartum appointments and to navigate their Medicaid benefits to get the services they need.*
  - *Case management can be involved from the beginning of pregnancy up to 12 weeks postpartum.*
- We partner with Count the Kicks and utilize the organization's materials and methods as an additional tool, as we work to educate and equip our members with the health-related tools and resources they need.

Long Term Supports & Services

Community Based Case Management is embedded in Iowa Medicaid LTSS services. It is a daily, comprehensive engagement with members that provides connection to medical, behavioral, employment and other services and supports that treat the whole person and enhance the member experience.

One of the key aspects of community-based case management is **assisting members with safely transitioning from facilities to community settings** as appropriate for the member. Services provided in the community offer members better opportunities for family and community interaction, employment and cultural and social experiences among other significant benefits.

Foster Care & Young Adults

- **Increased Interventions for Children in Foster Care** -- Early intervention and support for children in the foster care system including preparation for the transition to adulthood through intensive case management to meet challenges including health record portability, education and training of family, social supports about their needs.

- **Increased Community Integration for Young Adults with Complex Needs** – We placed a focus on young adults with complex behavioral health needs by identifying and partnering with high quality Iowa providers who bring the expertise necessary to meet the significant needs presented. These members had spent extensive amounts of time, years or decades, in out of state facility placements. Now they graduate high school, work at Hy-Vee, go to the YMCA.

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Amerigroup Iowa Innovative Population Health Interventions

Promising Current Clinical Initiatives deployed for the Iowa Medicaid member population

2019-20 Interventions

LTSS

- Skilled Nursing Facility (SNF) Length of Stay Project
- Adult Transitional Case Management
- Partnership with IVRS & IowaWORKS

Behavioral Health

- Opioid Risk Predictor Model Implementation
- Re-entry Coordination Specialists
- Certified Peer Support & Wellness/Recovery Specialists

Medical

- Physical Health Utilization Management Discharge Planners

Social Drivers of Health

Amerigroup Iowa has launched pilot projects in 2019 addressing our members' Social Drivers of Health in housing, nutrition, and economic security:

- **SDOH** – Responding to an enterprise-wide initiative, took the lead to develop a health plan-wide workgroup specific to development of the SDOH programs. Focusing on development of SDOH pilot projects in at least the following areas: Food insecurity, employment, and stable housing.

- **Monroe (CHAMP)** – Pilot for 2019-20 showcases our integrated case management capability in a first of its kind partnership with a public elementary school as the community hub around which outreach is centered. The pilot will primarily be housing-focused, but will affect other social determinants for Amerigroup members.

- **Employment** -- Partnership with Iowa Vocational Rehabilitation and IowaWORKS: Building 1-year apprenticeship training program for participants w/barriers to employment opportunities. Working to expand use of IPS services in Iowa.

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Value-Based Purchasing

Amerigroup Iowa is making real progress on value-based purchasing (VBP) arrangements with many types of Iowa providers, which is improving quality, more effectively managing limited Medicaid funds and creating innovation

- Amerigroup has 48% of members receiving services from providers in quality-based value-based contracts with health systems, modest-sized clinics & nearly all FQHCs
- Total quality incentive award from Amerigroup Iowa to our participating Iowa providers for the most recent full year of the VBP program was $1.7 million (does not include health systems).
- Rolled out in 2018 & maintained or expanded nine Quality Incentive Programs (QIP) for primary care, behavioral health, LTSS facility and community service providers, and OB providers.

Questions & Discussion